The Commonwealth of Massachusetts
Center for Health Information and Analysis

The Massachusetts All-Payer Claims Database

Medical Claim File Submission Guide

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Introduction

Access to timely, accurate, and relevant data is essential to improving quality, mitigating costs, and promoting transparency and efficiency in the health care delivery system. A valuable source of data can be found in health care claims but it is currently collected by a variety of government entities in various formats and levels of completeness. Using its broad authority to collect health care data ("without limitation") under M.G.L. c. 118G, § 6 and 6A, the Center for Health Information and Analysis (CHIA) has adopted regulations to create a comprehensive all payer claims database (APCD) with medical, pharmacy, and dental claims as well as provider, product, and member eligibility information derived from fully-insured, self-insured, Medicare, Medicaid and Supplemental Policy data. CHIA is a clearinghouse for comprehensive quality and cost information to ensure consumers, employers, insurers, and government have the data necessary to make prudent health care purchasing decisions.

To facilitate communication and collaboration, CHIA maintains a dedicated MA APCD website (www.mass.gov/chia/apcd) with resources that currently include the submission and release regulations, Administrative Bulletins, the technical submission guide with examples, and support documentation. These resources will be periodically updated with materials and the CHIA staff will continue to work with all affected submitters to ensure full compliance with the regulation.

While CHIA is committed to establishing and maintaining an APCD that promotes transparency, improves health care quality, and mitigates health care costs, we welcome your ongoing suggestions for revising reporting requirements that facilitate our shared goal of administrative simplification. If you have any questions regarding the regulations or technical specifications we encourage you to utilize the online resources and reach out to our staff for any further questions.

Thank you for your partnership with CHIA on the all payer claims database.

114.5 CMR 21.00 – Health Care Claims

114.5 CMR 21.00 governs the reporting requirements for Health Care Payers to submit data and information to CHIA in accordance with M.G.L. c. 118G, § 6. The regulation establishes the data submission requirements for health care payers to submit information concerning the costs and utilization of health care in Massachusetts. CHIA will collect data essential for the continued monitoring of health care cost trends, minimize the duplication of data submissions by payers to state entities, and to promote administrative simplification among state entities in Massachusetts.

Health care data and information submitted by Health Care Payers to CHIA is not a public record. No public disclosure of any health plan information or data shall be made unless specifically authorized under 114.5 CMR 21.00 or 114.5 CMR 22.00.

Acronyms Frequently Used

APCD – All-Payer Claims Database

CHIA – Center for Health Information and Analysis

CSO – Computer Services Organization

DBA – Delegated Benefit Administrator

DBM – Dental Benefit Manager

DOI – Division of Insurance

GIC – Group Insurance Commission

ID – Identification; Identifier

MA APCD – Massachusetts' All-Payer Claims Database

PBM – Pharmacy Benefit Manager

QA – Quality Assurance

RA – Risk Adjustment; Risk Adjuster

TME / RP – Total Medical Expense / Relative Pricing

TPA – Third Party Administrator

<u>The File Types:</u>

DC – Dental Claims

MC – Medical Claims

ME – Member Eligibility

PC – Pharmacy Claims

PR – Product File

PV – Provider File

The APCD Monthly Medical Claims File

As part of the MA APCD, submitters are required to submit a Medical Claims File. CHIA, in an effort to decrease any programming burden, has maintained the file layout previously used. There are minor changes to this layout so that it will connect appropriately across other required filings for the MA APCD and a few added elements to aid with line of business identification for better-directed editing of the data.

Below we have provided details on business rules, data definitions and the potential uses of this data.

Specification Question	Clarification	Rationale
Frequency of submission	Medical claim files are to be submitted monthly	CHIA requires this frequency to maintain a current dataset for analysis.
What is the format of the file	Each submission must be a variable field length asterisk delimited file	An asterisk cannot be used within an element in lieu of another character. Example: if the file includes "Smith*Jones" in the Last Name, the system will read an incorrect number of elements and drop the file.
What each row in the file represents	Each row represents a claim line. If there are multiple services performed and billed on a claim, each of those services will be uniquely identified and reported on a line.	It is necessary to obtain line item data to better understand how services are perceived and adjudicated by different carriers.
Won't reporting claim lines create redundancy?	Yes, certain data elements of claim level data will be repeated in every row in order to report unique line item processing. The repeated claim level data will be de-duplicated at CHIA.	Claim-line level data is required to capture accurate details of claims and encounters.
Are denied claims to be reported?	No. Wholly denied claims should not be reported at this time. However, if a single procedure is denied	Denied line items of an adjudicated claim aid with cost analysis.

	within a paid claim that denied line should be reported.	
Should claims that are paid under a 'global payment', or 'capitated payment' thus zero paid, be reported in this file.	Yes. Any medical claim that is considered 'paid' by the carrier should appear in this filing. Paid amount should be reported as 0 and the corresponding Allowed, Contractual, Deductible Amounts should be calculated accordingly.	The reporting of Zero Paid Medical Claims is required to accurately capture encounters and to further understand contractual arrangements.
Should previously paid but now Voided claims be reported?	Yes. Claims that were paid and reported in one period and voided by either the Provider or the Carrier in a subsequent period should be reported in the subsequent file. See MC139 below.	The reporting of Voided Claims maintains logic integrity related to medical costs and utilization.
What types of claims are to be included?	The Medical Claims file is used to report both institutional and professional claims. The unique elements that apply to each are included; however only those elements that apply to the claim type should be submitted. Example: Diagnostic Pointer is a Professional Claim element and would not be a required element on an Institutional Claim record. See MC094 below for claim type ID.	CHIA has adopted the most widely used specification at this time. It is important to note that by adhering to claim rules for each specific type will provide cleaner analysis.
The word 'Member' is used in the specification. Are 'Member' and 'Patient' used synonymously?	Yes. Member and Patient are to be used in the same manner in this specification	Member is used in the claim specification to strengthen the reporting bond between Member Eligibility and the claims attached to a Member.

If claims are processed by a third-party administrator, who is responsible for submitting the data and how should the data be submitted?	In instances where more than one entity administers a health plan, the health care carrier **and** third-party administrators are responsible for submitting data according to the specifications and format defined in the Submission Guides.	CHIA's objective is to create a **comprehensive** All-Payer database which must include data from all health care carriers and third-party administrators.

Types of Data collected in the Medical Claim File

Submitter-assigned Identifiers

CHIA requires various Submitter-assigned identifiers for matching-logic to the other files, Product and Member Eligibility. Some examples of these elements include MC003, MC006, MC137 and MC141. These element s will be used by CHIA to aid with the matching algorithm to those other files. This matching allows for data aggregation and required reporting.

Claims Data

CHIA requires the line-level detail of all Medical Claims for analysis. The line-level data aids with understanding utilization within products across submitters. The specific medical data reported in the majority of the MC file correspond to elements found on the UB04, HCFA 1500 and the HIPAA 837I and 837P data sets or a Carrier specific direct data entry system.

Subscriber and Member (Patient) submitter unique identifiers are being requested to aid with the matching algorithm, see MC137 and MC141.

Elements MC024-MC035 - Servicing provider data:
The set of elements MC024-MC035 are all related to the servicing provider **entity**. CHIA collects entity level rendering provider information here, and at the lowest level achievable by the submitter.

If the submitter only knows the billing entity, and the billing entity is not a ***service rendering*** provider, then the billing provider data (MC076-MC078) is ***not*** appropriate. In this case the submitter would need a variance request for the service provider elements.

If the carrier only has the data for a main ***service rendering*** site but not the specific satellite information where services are rendered, then the main service site ***is*** acceptable for the service provider elements.

For example – XYZ Orthopedic Group is acceptable, if XYZ Orthopedic Group Westside is not available. However, XYZ Orthopedic Group Westside is preferable, and ultimately the goal.

A physician's office is also appropriate here, but not the physician. The physician or other person providing the service is expected in MC134.

Elements MC134 Plan Rendering Provider and MC135 Provider Location:
These elements should describe precisely who performed the services on the patient and where the service was rendered. If the carrier does not know who actually performed the service or the specific site where the service was actually performed, the carrier will need a variance request for one or both of these elements. It is not appropriate to load facility or billing information here in MC134.

> **MC134 – Plan Rendering Provider:** The intent of this element is to capture the details of the individual that performed the service on the patient or for the patient (lab technician, supply delivery, etc.).
>
> **MC135 – Provider Location:** The intent of this element is to capture the details of the site where the Plan Rendering Provider delivered those services (Office, Hospital, etc.) For Home Services this location ID should be the Suppliers ID.

Non-Massachusetts Resident

The regulation requires private health care payers to submit Medical Claims and Encounter Data for "all Massachusetts resident members, and all members of a Massachusetts employer group including those who reside outside of Massachusetts."

CHIA will not require payers submitting claims and encounter data on behalf of an employer group to submit claims data for employees who reside outside of Massachusetts, unless the payer is required by contract with the Group Insurance Commission to submit paid claims and encounter data for all Massachusetts residents, and all members of a Massachusetts employer group including those who reside outside of Massachusetts.

Provider data is outlined below.

Adjudication Data

CHIA requires adjudication-centric data on the MC file for analysis of Member Eligibility to Product. The elements typically used in an adjudication process are MC017 through MC023, MC036 through MC038, MC063 through MC069, MC071 through MC075, MC080, MC081, MC089, MC092 through MC099, MC113 through MC119, MC122 through MC124, MC128, and MC138 and are variations of paper remittances or the HIPAA 835 4010.

CHIA has made a conscious decision to collect numerous identifiers that may be associated with a provider. The provider identifiers will be used to help link providers across carriers in the event that the primary linking data elements are not a complete match. The existence of these extra identifying elements in claims are part of our quality

assurance process, and will be analyzed in conjunction with the provider file. We expect this will improve the quality of our matching algorithms within and across carriers.

> **Denied Claims:** Payers will be not be required to submit wholly denied claims at this time. CHIA will issue an Administrative Bulletin notifying Submitters when the requirement to submit denied claims will become effective, the detailed process required to identify and report, and the due dates of denied claim reporting.

The Provider ID

Element MC024 (Service Provider ID), MC134 (Plan Rendering Provider) and MC135 (Provider Location) are critical elements in the MA APCD process as it links the Provider identified on the Medical Claims file with the corresponding Provider ID (PV002) in the Provider File. The definition of the PV002 element is:

The Provider ID is a unique number for every service provider (persons, facilities or other entities involved in claims transactions) that a carrier has in its system. This element may or may not be the provider NPI and this element is used to uniquely identify a provider and that provider's affiliation, when applicable as well as the provider's practice location within this provider file.

The following are the elements that are required to link to PV002:
Medical Claim Links: MC024 – Service Provider Number; **MC076** – Billing Provider Number; **MC112** – Referring Provider ID; **MC125** – Attending Provider; **MC134** – Plan Rendering Provider Identifier; **MC135** – Provider Location

The goal of PV002, Provider ID, is to help identify provider data elements associated with provider data that was submitted in the claim line detail, and to identify the details of the Provider Affiliation.

New Data Elements

Under Administrative Simplification, CHIA has worked with Division of Insurance, The Connector, Group Insurance Commission and our own internal departments to identify new elements to be added to the MA APCD Dataset to satisfy that goal. Below is a list of those elements, the submitter type expected to report them, the reason and the data expected within the element.

MC091 – Coinsurance Days; *all submitters, conditionally required on inpatient facility claims*

> This new element on the MC File is used to determine a type of covered benefit days as defined by Medicare. Submitters that use a similar methodology are

encouraged to report the appropriate number of days that correspond with the Medicare definition.

MC107 – ICD Indicator; *all submitters, required to invoke the correct ICD version edits*

This new element is required and becomes invoked when any Diagnosis Element is populated. It is required to insure that clinical editing and categorization occurs correctly and is assumed to report ICD9 until ICD10 implementation. The values present on the MA APCD table align to those used by the Center for Medicare and Medicaid Services to provide continuity across submitters.

MC121 – Patient Total Out of Pocket Expense; *all submitters, required for all claim lines*

This new element on the MC File is required to measure patient / member out of pocket expenses in correlation to the benefits assigned on the eligibility file. Submitters should report 0 when there is no out of pocket expense for a claim line.

MC133 – Bill Frequency Code; *all submitters, required on all facility and professional claims*

This new element on the MC file is required to identify aspects of claim line activity for versioning lines to the highest value. The allowable values are those that are generally accepted.

MC142 thru MC153 – Other Diagnoses 13 thru 24; *all submitters, conditionally required*

This new set of elements was added to supplement the current diagnosis reporting of Primary through 12. The additional diagnoses aid with comprehensive grouping and reporting of data, and provide additional detail to clinical analyses.

MC154 thru MC178 – Present on Admission Codes 01 thru 25; *all submitters, conditionally required*

This new set of elements was added to allow the MA APCD to group inpatient facility claims in more recent versions of the clinical grouper. Clinical grouping at CHIA allows for standardized DRG and APC assignment and reduces the burden on submitters that do not utilize DRG or APC for their clinical / payment systems.

MC179 thru MC190 – Condition Codes 01 thru 12; *all submitters, conditionally required*

This new set of elements was added so that submitters could provide greater detail on facility claims that related to specific conditions of the claim / provider / patient and have an impact on the claim processing and payment.

MC191 thru MC214 – Value Code and Amount 01 thru 12; *all submitters, conditionally required*

This new set of elements was added so that submitters could provide a greater detail on facility claims that related to specific amounts of the claim / provider / patient and have an impact on the claim processing and payment.

MC215 thru 224 – Occurrence Code and Date 01 thru 05; *all submitters, conditionally required*

This new set of elements was added so that submitters could provide a greater detail on facility claims that related to specific occurrences of the claim / provider / patient and have an impact on the claim processing and payment.

MC225 thru MC239 – Occurrence Span Code and Dates 01 thru 05; *all submitters, conditionally required*

This new set of elements was added so that submitters could provide a greater detail on facility claims that related to specific occurrence span dates of the claim / provider / patient and have an impact on the claim processing and payment.

MC240 – GIC ID; *all GIC Contracted Carriers, to aid with GIC reporting requirements*

This new element is to report the GIC assigned identifier from the member. The presence of this identifier is dependent upon the value reported in PC120. Non-GIC reporters SHOULD NOT report a value here as this will invoke other data elements that may not be applicable to a line of business.

MC241 – APCD ID Code; *all APCD submitters, to aid with data requirements and edits*

The new element utilizes a new MA APCD pre-defined lookup table with the values for identifying a line of eligibility being categorized as a Fully Insured Group Enrollee, Self-Insured Group Enrollee, GIC Group Enrollee, MassHealth MCO Enrollee, Supplement Policy Enrollee or Unknown. The value selected here will invoke various edits that apply to that enrollee category in tandem with the CHIA assigned OrgID. Please note selecting an incorrect category will invoke edits on elements not typically populated by submitter type and may create a Failed File for not meeting base thresholds. Additionally, OrgIDs that submit Unknown 100% of the time but have been identified as one of the other values will inadvertently Fail their file.

CHIA is committed to working with all submitters and their technical teams to ensure compliance with applicable laws and regulations. CHIA will continue to provide support through technical assistance calls and resources available on the CHIA website, www.mass.gov/chia

File Guideline and Layout

Legend

1. File: Identifies the file per element as well as the Header and Trailer Records that repeat on all MA APCD File Types. Headers and Trailers are Mandatory as a whole, with just a few elements allowing situational reporting.
2. Col: Identifies the column the data resides in when reported
3. Elmt: This is the number of the element in regards to the file type
4. Date Element Name: Provides identification of basic data required
5. Date Modified: Identifies the last date that an element was adjusted
6. Type: Defines the data as Decimal, Integer, Numeric or Text. Additional information provided for identification, e.g., Date Period – Integer
7. Type Description: Used to group like-items together for quick identification
8. Format / Length: Defines both the reporting length and element min/max requirements. See below:
    a. char[n] – this is a fixed length element of [n] characters, cannot report below or above [n]. This can be any type of data, but is governed by the type listed for the element, Text vs. Numeric.
    b. varchar[n] – this is a variable length field of max [n] characters, cannot report above [n]. This can be any type of data, but is governed by the type listed for the element, Text vs. Numeric.
    c. int[n] – this is a fixed type and length element of [n] for numeric reporting only. This cannot be anything but numeric with no decimal points or leading zeros.

    The plus/minus symbol (±) in front on any of the Formats above indicate that a negative can be submitted in the element under specific conditions. **Example:** When the Claim Line Type (MC138) = V (void) or B (backout) then certain claim values can be negative.
9. Description: Short description that defines the data expected in the element
10. Element Submission Guideline: Provides detailed information regarding the data required as well as constraints, exceptions and examples.
11. Condition: Provides the condition for reporting the given data
12. %: Provides the base percentage that the MA APCD is expecting in volume of data in regards to condition requirements.
13. Cat: Provides the category or tiering of elements and reporting margins where applicable.

Elements that are highlighted indicate that a MA APCD lookup table is present and contains valid values expected in the element. In very few cases, there is a combination of a MA APCD lookup table and an External Code Source or Carrier Defined Table, these maintain the highlight.

It is important to note that Type, Format/Length, Condition, Threshold and Category are considered as a suite of requirements that the intake edits are built around to insure compliance, continuity and quality. This insures that the data can be standardized at other levels for greater understanding of healthcare utilization.

File	Col	Elmt	Data Element Name	Date Modified	Type	Type Description	Format / Length	Description	Element Submission Guideline	Condition	%	Cat
HD-MC	1	HD001	Record Type	11/8/12	Text	ID Record	char[2]	Header Record Identifier	Report **HD** here. Indicates the beginning of the Header Elements of the file	Mandatory	100%	HM
HD-MC	2	HD002	Submitter	11/8/12	Integer	ID OrgID	varchar[6]	Header Submitter / Carrier ID defined by CHIA	Report CHIA defined, unique Submitter ID here. TR002 must match the Submitter ID reported here. This ID is linked to other elements in the file for quality control	Mandatory	100%	HM
HD-MC	3	HD003	National Plan ID	11/8/12	Integer	ID Nat'l PlanID	int[10]	Header CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans	Situational	0%	HS
HD-MC	4	HD004	Type of File	11/8/12	Text	ID File	char[2]	Defines the file type and data expected.	Report **MC** here. Indicates that the data within this file is expected to be MEDICAL CLAIM-based. This must match the File Type reported in TR004	Mandatory	100%	HM
HD-MC	5	HD005	Period Beginning Date	11/8/12	Date Period - Integer	Century Year Month - CCYYMM	int[6]	Header Period Start Date	Report the Year and Month of the reported submission period in CCYYMM format. This date period must be repeated in HD006, TR005 and TR006. This same date must be selected in the upload application for successful transfer.	Mandatory	100%	HM
HD-MC	6	HD006	Period Ending Date	11/8/12	Date Period - Integer	Century Year Month - CCYYMM	int[6]	Header Period Ending Date	Report the Year and Month of the reporting submission period in CCYYMM format. This date period must match the date period reported in HD005 and be repeated in TR005 and TR006	Mandatory	100%	HM

HD - MC	7	HD007	Record Count	11/8/12	Integer	Counter	varchar[10]	Header Record Count	Report the total number of records submitted within this file. Do not report leading zeros, space fill, decimals, or any special characters.	Mandatory	100%	HM
HD - MC	8	HD008	Comments	11/8/12	Text	Free Text Field	varchar[80]	Header Carrier Comments	May be used to document the submission by assigning a filename, system source, compile identifier, etc.	Optional	0%	HO
HD - MC	9	HD009	APCD Version Number	11/8/12	Decimal - Numeric	ID Version	char[3]	Submission Guide Version	Report the version number as presented on the APCD Medical Claim File Submission Guide in 0.0 Format. Sets the intake control for editing elements. Version must be accurate else file will drop. **EXAMPLE:** 3.0 = Newest Version	Mandatory	100%	HM
								Code	***Description***			
								2.1	Prior Version; valid only for reporting periods prior to May 2013			
								3.0	Current Version; required for reporting periods as of May 2013			
MC	1	MC001	Submitter	11/8/12	Integer	ID Submitter	varchar[6]	CHIA defined and maintained unique identifier	Report the Unique Submitter ID as defined by CHIA here. This must match the Submitter ID reported in HD002	All	100%	A0
MC	2	MC002	National Plan ID	11/8/12	Integer	ID Nat'l PlanID	int[10]	CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans	All	0%	Z
MC	3	MC003	Insurance Type Code/Product	11/8/12	Lookup Table - Text	tlkpClaimInsuranceType	char[2]	Type / Product Identification Code	Report the code that defines the type of insurance under which this patient's claim line was processed. **EXAMPLE:** HM = HMO	All	92%	C
								Code	***Description***			
								09	Self-pay			
								10	Central Certification			
								11	Other Non-Federal Programs			
								12	Preferred Provider Organization (PPO)			
								13	Point of Service (POS)			

								14	Exclusive Provider Organization (EPO)			
								15	Indemnity Insurance			
								16	Health Maintenance Organization (HMO) Medicare Risk			
								17	Dental Maintenance Organization (DMO)			
								AM	Automobile Medical			
								BL	Blue Cross / Blue Shield			
								CC	Commonwealth Care			
								CE	Commonwealth Choice			
								CH	Champus			
								CI	Commercial Insurance Co.			
								DS	Disability			
								HM	Health Maintenance Organization			
								LI	Liability			
								LM	Liability Medical			
								MA	Medicare Part A			
								MB	Medicare Part B			
								MC	Medicaid			
								OF	Other Federal Program			
								TF	HSN Trust Fund			
								TV	Title V			
								VA	Veterans Administration Plan			
								WC	Workers' Compensation			
								ZZ	Other			
MC	4	MC004	Payer Claim Control Number	6/24/10	Text	ID Claim Number	varchar[35]	Payer Claim Control Identification	Report the Unique identifier within the payer's system that applies to the entire claim	All	100%	A0

MC	5	MC005	Line Counter	11/8/12	Integer	ID Count	varchar[4}	Incremental Line Counter	Report the line number for this service within the claim. Start with 1 and increment by 1 for each additional line. Do not start with 0, include alphas or special characters.	All	100%	A0
MC	6	MC005A	Version Number	6/24/10	Integer	Counter	varchar[4]	Claim Service Line Version Number	Report the version number of this claim service line. The version number begins with 0 and is incremented by 1 for each subsequent version of that service line. No alpha or special characters.	All	100%	A0
MC	7	MC006	Insured Group or Policy Number	6/24/10	Text	ID Group	varchar[30]	Group / Policy Number	Report the number that defines the insured group or policy. Do not report the number that uniquely identifies the subscriber or member	All	95%	C
MC	8	MC007	Subscriber SSN	11/8/12	Numeric	ID Tax	char[9]	Subscriber's Social Security Number	Report the Subscriber's SSN here; used to validate Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here	All	79%	B
MC	9	MC008	Plan Specific Contract Number	6/24/10	Text	ID Contract	varchar[30]	Contract Number	Report the Plan assigned contract number. Do not include values in this field that will distinguish one member of the family from another. This should be the contract or certificate number for the subscriber and all of the dependents.	All	98%	C
MC	10	MC009	Member Suffix or Sequence Number	6/24/10	Text	ID Sequence	varchar[20]	Member/Patient's Contract Sequence Number	Report the unique number / identifier of the member / patient within the contract	All	98%	B
MC	11	MC010	Member SSN	11/8/12	Numeric	ID Tax	char[9]	Member/Patient's Social Security Number	Report the patient's social security number here; used to validate Unique Member ID; will not be passed into analytic file. Do not use hyphen. If not available do not report any value here	All	73%	B
MC	12	MC011	Individual Relationship Code	6/24/10	Lookup Table - Text	tlkpIndividualRelathionshipCode	char[2]	Patient to Subscriber Relationship Code	Report the value that defines the Patient's relationship to the Subscriber. **EXAMPLE:** 20 = Self / Employee	All	98%	B
								Value	***Description***			
								01	Spouse			

								04	Grandfather or Grandmother			
								05	Grandson or Granddaughter			
								07	Nephew or Niece			
								10	Foster Child			
								15	Ward			
								17	Stepson or Stepdaughter			
								19	Child			
								20	Self/Employee			
								21	Unknown			
								22	Handicapped Dependent			
								23	Sponsored Dependent			
								24	Dependent of a Minor Dependent			
								29	Significant Other			
								32	Mother			
								33	Father			
								36	Emancipated Minor			
								39	Organ Donor			
								40	Cadaver Donor			
								41	Injured Plaintiff			
								43	Child Where Insured Has No Financial Responsibility			
								53	Life Partner			
								76	Dependent			
MC	13	MC012	Member Gender	6/24/10	Lookup Table - Text	tlkpGender	char[1]	Patient's Gender	Report patient gender as found on the claim in alpha format. Used to validate clinical services when applicable and Unique Member ID. **EXAMPLE:** F = Female	All	98%	B
								Code	***Description***			
								F	Female			

								M	Male			
								O	Other			
								U	Unknown			
MC	14	MC013	Member Date of Birth	6/24/10	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Member/Patient's date of birth	Report the date the member / patient was born in CCYYMMDD Format. Used to validate Unique Member ID.	All	98%	B
MC	15	MC014	Member City Name	6/24/10	Text	Address City Member	varchar[30]	City name of the Member/Patient	Report the city name of the member / patient. Used to validate Unique Member ID	All	98%	B
MC	16	MC015	Member State	11/8/12	External Code Source 2 - Text	Address State External Code Source 2 - States	char[2]	State / Province of the Patient	Report the state of the patient as defined by the US Postal Service. Report Province when Country Code does not = USA	All	98%	B
MC	17	MC016	Member ZIP Code	11/8/12	External Code Source 2 - Text	Address Zip External Code Source 2 - Zip Codes	varchar[9]	Zip Code of the Member / Patient	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	98%	B
MC	18	MC017	Date Service Approved (AP Date)	6/24/10	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Date Service Approved by Payer	Report the date that the payer approved this claim line for payment in CCYYMMDD Format. This element was designed to capture date other than the Paid date. If Approved Date and Paid Date are the same, then the date here should match Paid Date.	All	93%	C
MC	19	MC018	Admission Date	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Inpatient Admit Date	Report the date of admit to a facility in CCYYMMDD Format. Only applies to facility claims were Type of Bill = an inpatient setting.	Required when MC094 = 002 and MC039 is populated	98%	A1
MC	20	MC019	Admission Hour	11/8/12	Numeric	Time Period Hour Minutes	char[4]	Admission Time	Report the Admit Time in HHMM Format. Only applies to facility claims were Type of Bill = an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as 00. 4 AM would be reported as 0400; 4 PM would be reported as 1600.	Required when MC094 = 002 and MC039 is populated	5%	C
MC	21	MC020	Admission Type	11/8/12	External Code	External Code Source 14 -	int[1]	Admission Type Code	Report Admit Type as it applies to facility claims were Type of Bill = an	Required when	98%	A1

					Source 14 - Integer	Admission Type			inpatient setting. This code indicates the type of admission into an inpatient setting. Also known as Admission Priority.	MC094 = 002 and MC039 is populated		
MC	22	MC021	Admission Source	11/8/12	External Code Source 14 - Text	External Code Source 14 - Admission Source	char[1]	Admission Source Code	Report the code that applies to facility claims were Type of Bill = an inpatient setting. This code indicates how the patient was referred into an inpatient setting at the facility.	Required when MC094 = 002 and MC039 is populated	98%	A1
MC	23	MC022	Discharge Hour	11/8/12	Numeric	Time Period Hour Minutes	char[4]	Discharge Time	Report the Discharge Time in HHMM Format. Only applies to facility claims were Type of Bill = an inpatient setting. Time is expressed in military time. If only the hour is known, code the minutes as 00. 4 AM would be reported as 0400; 4 PM would be reported as 1600.	Required when MC094 = 002 and MC069 is populated	5%	C
MC	24	MC023	Discharge Status	11/8/12	External Code Source 14 - Numeric	External Code Source 14 - Discharge Status	char[2]	Inpatient Discharge Status Code	Report the appropriate Discharge Status Code of the patient as defined by External Code Source	Required when MC094 = 002 and MC069 is populated	98%	A1
MC	25	MC024	Service Provider Number	6/24/10	Text	ID Link to PV002	varchar[30]	Service Provider Identification Number	Report the carrier / submitter assigned billing provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this field must match a record in the provider file in PV002.	All	99%	A1
MC	26	MC025	Service Provider Tax ID Number	11/8/12	Numeric	ID Tax	char[9]	Service Provider's Tax ID number	Report the Federal Tax ID of the Service Provider here. Do not use hyphen or alpha prefix.	All	97%	C
MC	27	MC026	National Provider ID - Service	11/8/12	External Code Source 3 - Integer	External Code Source 3 - National Provider ID	int[10]	National Provider Identification (NPI) of the Service Provider	Report the Primary National Provider ID (NPI) of the Servicing Provider in MC024. This ID should be found on the Provider File in the NPI Field (PV039)	All	98%	C
MC	28	MC027	Service Provider Entity Type	11/8/12	Lookup Table - integer	tlkpServProvEntityTypeQualifier	int[1]	Service Provider Entity Identifier Code	Report the value that defines the provider entity type. Only individuals should be identified with a 1.	All	98%	A0

			Qualifier						Facilities, professional groups and clinic sites should all be identified with a 2. **EXAMPLE:** 1 = Person			
								Value	***Description***			
								1	Person			
								2	Non-person entity			
MC	29	MC028	Service Provider First Name	11/8/12	Text	Name First Provider	varchar[25]	First name of Service Provider	Report the individual's first name here. If provider is a facility or organization , do not report any value here	All	92%	C
MC	30	MC029	Service Provider Middle Name	11/8/12	Text	Name Middle Provider	varchar[25]	Middle initial of Service Provider	Report the individual's middle name here. If provider is a facility or organization , do not report any value here	All	2%	C
MC	31	MC030	Servicing Provider Last Name or Organization Name	6/24/10	Text	Name Last / Org Provider	varchar[60]	Last name or Organization Name of Service Provider	Report the name of the organization or last name of the individual provider. MC027 determines if this is an Organization or Individual Name reported here.	All	94%	A2
MC	32	MC031	Service Provider Suffix	10/15/10	Lookup Table - Integer	tlkpLastNameSuffix	int[1]	Provider Name Suffix	Report the individuals name-suffix when applicable here. Used to capture the generation of the individual clinician (e.g., Jr. Sr., III). Do not report degree acronyms here. **EXAMPLE:** 0 = Unknown / Not Applicable	All	2%	Z
								Value	***Description***			
								1	I.			
								2	II.			
								3	III.			
								4	Jr.			
								5	Sr.			
								0	Unknown / Not Applicable			
MC	33	MC032	Service Provider Taxonomy	11/8/12	External Code Source 5 - Text	External Code Source 5 - Taxonomy	varchar[10]	Taxonomy Code	Report the standard code that defines this provider for this line of service. Taxonomy values allow for the reporting of nurses, assistants	All	98%	A2

									and laboratory technicians, where applicable, as well as Physicians, Medical Groups, Facilities, etc.			
MC	34	MC033	Service Provider City Name	6/24/10	Text	Address City Provider	varchar[30]	City Name of the Provider	Report the city name of provider - preferably practice location. Do not report any value if not available.	All	98%	B
MC	35	MC034	Service Provider State	11/8/12	External Code Source 2 - Text	Address State External Code Source 2 - States	char[2]	State of the Service Provider	Report the state of the service providers as defined by the US Postal Service. Do not report any value if not available.	All	98%	B
MC	36	MC035	Service Provider ZIP Code	11/8/12	External Code Source 2 - Text	Address Zip External Code Source 2 - Zip Codes	varchar[9]	Zip Code of the Service Provider	Report the 5 or 9 digit Zip Code as defined by the United States Postal Service. When submitting the 9-digit Zip Code do not include hyphen.	All	98%	B
MC	37	MC036	Type of Bill - on Facility Claims	11/8/12	External Code Source 14 - Integer	External Code Source 14 - Type of Bill	int[2]	Type of Bill	Report the two-digit value that defines the Type of Bill on an institutional claim. Do not report leading zero	Required when MC094 = 002	98%	A0
MC	38	MC037	Site of Service - on NSF/CMS 1500 Claims	11/8/12	External Code Source 13 - Numeric	External Code Source 13 - Place of Service	char[2]	Place of Service Code	Report the two-digit value that defines the Place of Service on professional claim	Required when MC094 = 001	100%	A0
MC	39	MC038	Claim Status	11/8/12	Lookup Table - Numeric	tlkpClaimStatus	varchar[2]	Claim Line Status	Report the value that defines the payment status of this claim line	All	98%	A0

Value	***Description***
1	Processed as primary
2	Processed as secondary
3	Processed as tertiary
4	Denied
19	Processed as primary, forwarded to additional payer(s)
20	Processed as secondary, forwarded to additional payer(s)
21	Processed as tertiary, forwarded to additional payer(s)
22	Reversal of previous payment

								23	Not our claim, forwarded to additional payer(s)			
								25	Predetermination Pricing Only - no payment			
MC	40	MC039	Admitting Diagnosis	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	Admitting Diagnosis Code	Report the diagnostic code assigned by provider that supported admission into the inpatient setting	Required when MC094 = 002 and MC036 = 11, 18, 21, 28, 41, 65, 66, 84, 86, or 89	98%	A1
MC	41	MC040	E-Code	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Diagnostic External Injury Code	Report the external injury code for patient when appropriate to the claim	All	3%	C
MC	42	MC041	Principal Diagnosis	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Primary Diagnosis Code	Report the Primary ICD Diagnosis Code here	All	99%	A0
MC	43	MC042	Other Diagnosis - 1	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Secondary Diagnosis Code	Report the Secondary ICD Diagnosis Code here	All	70%	B
MC	44	MC043	Other Diagnosis - 2	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 2.	All	24%	B
MC	45	MC044	Other Diagnosis - 3	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 3.	All	13%	C

MC	46	MC045	Other Diagnosis - 4	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 4. If not applicable do not report any value here	All	7%	C
MC	47	MC046	Other Diagnosis - 5	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 5. If not applicable do not report any value here	All	4%	C
MC	48	MC047	Other Diagnosis - 6	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 6. If not applicable do not report any value here	All	3%	C
MC	49	MC048	Other Diagnosis - 7	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 7. If not applicable do not report any value here	All	3%	C
MC	50	MC049	Other Diagnosis - 8	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 8. If not applicable do not report any value here	All	2%	C
MC	51	MC050	Other Diagnosis - 9	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 9. If not applicable do not report any value here	All	1%	C
MC	52	MC051	Other Diagnosis - 10	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 10. If not applicable do not report any value here.	All	1%	C

MC	53	MC052	Other Diagnosis - 11	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 11. If not applicable do not report any value here.	All	1%	C
MC	54	MC053	Other Diagnosis - 12	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 12. If not applicable do not report any value here.	All	1%	C
MC	55	MC054	Revenue Code	11/8/12	External Code Source 14 - Numeric	External Code Source 14 - Revenue Code	char[4]	Revenue Code	Report the valid National Uniform Billing Committee Revenue Code here. Code using leading zeroes, left-justified, and four digits.	Required when MC094 = 002	98%	A0
MC	56	MC055	Procedure Code	11/8/12	Carrier Defined Table **- OR -** External Code Source 9 - Text	External Code Source 9 - CPTs & HCPCS	varchar[10]	HCPCS / CPT Code	Report a valid Procedure code for the claim line as defined by MC130	All	98%	A1
MC	57	MC056	Procedure Modifier - 1	11/8/12	External Code Source 9 - Text	External Code Source 9 - Modifiers	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	All	20%	B
MC	58	MC057	Procedure Modifier - 2	11/8/12	External Code Source 9 - Text	External Code Source 9 - Modifiers	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	All	3%	B
MC	59	MC058	ICD9-CM Procedure Code	11/8/12	External Codes Source 8 - Text	External Code Source 8 - ICDCM Procedure Codes	varchar[6]	ICD Primary Procedure Code	Report the primary ICD CM procedure code when appropriate. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	Required when MC094 = 002 and MC039 is populated	98%	A2
MC	60	MC059	Date of Service - From	6/24/10	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Date of Service	Report the date of service for the claim line in CCYYMMDD Format.	All	98%	A0

MC	61	MC060	Date of Service - To	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Date of Service	Report the end service date for the claim line in CCYYMMDD Format. For inpatient claims, the room and board line may or may not be equal to the discharge date. Procedures delivered during a visit should indicate which date they occurred.	All	98%	A0
MC	62	MC061	Quantity	11/8/12	Quantity - Integer	Counter	±varchar[15]	Claim line units of service	Report the count of services / units performed.	All	98%	A1
MC	63	MC062	Charge Amount	11/8/12	Integer	Currency	±varchar[10]	Amount of provider charges for the claim line	Report the charge amount for this claim line. 0 dollar charges allowed only when the procedure code indicates a Category II procedure code vs. a service code. When reporting Total Charges for facilities for the entire claim use 001 (the generally accepted Total Charge Revenue Code) in MC054 (Revenue Code). Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%	A0
MC	64	MC063	Paid Amount	10/3/10	Integer	Currency	±varchar[10]	Amount paid by the carrier for the claim line	Report the amount paid for the claim line. Report 0 if line is paid as part of another procedure / claim line. Do not report any value if the line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%	A0
MC	65	MC064	Prepaid Amount	11/8/12	Integer	Currency	±varchar[10]	Amount carrier has prepaid towards the claim line	Report the prepaid amount for this claim line. Report the Fee for Service equivalent amount for Capitated services. Report 0 when there is no Prepaid amount. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	100%	A2

MC	66	MC065	Copay Amount	6/24/10	Integer	Currency	±varchar[10]	Amount of Copay member/patient is responsible to pay	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Copay applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%	A1
MC	67	MC066	Coinsurance Amount	6/24/10	Integer	Currency	±varchar[10]	Amount of coinsurance member/patient is responsible to pay	Report the amount that defines a calculated percentage amount for this claim line service that the patient is responsible to pay. Report 0 if no Coinsurance applies. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%	A1
MC	68	MC067	Deductible Amount	6/24/10	Integer	Currency	±varchar[10]	Amount of deductible member/patient is responsible to pay on the claim line	Report the amount that defines a preset, fixed amount for this claim line service that the patient is responsible to pay. Report 0 if no Deductible applies to service. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	99%	A1
MC	69	MC068	Patient Control Number	11/8/12	Text	ID Claim Number	varchar[20]	Patient Control Number	Report the provider assigned Encounter / Visit number to identify patient treatment. Also known as the Patient Account Number	Required when MC094 = 002	98%	A2
MC	70	MC069	Discharge Date	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Discharge Date	Report the date the member was discharged from the facility in CCYYMMDD Format. If patient is still in-house and claim represents interim billing for interim payment, report the interim through date.	Required when MC094 = 002 and MC039 is populated	98%	A2
MC	71	MC070	Service Provider Country Code	12/1/10	External Code Source 1 - Text	Address Country External Code Source 1 - Countries	char[3]	Country name of the Service Provider	Report the three-character country code as defined by ISO 3166-1, Alpha 3	All	98%	C

MC	72	MC071	DRG	11/8/12	External Code Source 15 - Text	External Code Source 15 - DRG	varchar[7]	Diagnostic Related Group Code	Report the DRG number applied to this claim on every line to which it's applicable. Insurers and health care claims processors shall code using the CMS methodology when available. When the CMS methodology for DRGs is not available, but the All Payer DRG system is used, the insurer shall format the DRG and the complexity level within the same element with the prefix of "A" and with a hyphen separating the AP DRG from the complexity level (e.g. AXXX-XX)	Required when MC094 = 002 and MC069 is populated	98%	B
MC	73	MC072	DRG Version	11/8/12	External Code Source 15 - Text	External Code Source 15 - DRG	char[2]	Diagnostic Related Group Version Number	Report the version of the grouper used	Required when MC071 is populated	20%	B
MC	74	MC073	APC	11/8/12	External Code Source 15 - Text	External Code Source 15 - DRG	char[4]	Ambulatory Payment Classification Number	Report the APC number applied to this claim line, with the leading zero(s) when applicable. Code using the CMS methodology.	Required when MC094 = 002 and MC039 is null	20%	C
MC	75	MC074	APC Version	11/8/12	External Code Source 15 - Text	External Code Source 15 - DRG	char[2]	Ambulatory Payment Classification Version	Report the version of the grouper used	Required when MC073 is populated	20%	C
MC	76	MC075	Drug Code	6/24/10	External Code Source 12 - Text	External Code Source 12 - National Drug Codes	char[11]	National Drug Code (NDC)	Report the NDC code used only when a medication is paid for as part of a medical claim or when a DME device has an NDC code. J codes should be submitted under procedure code (MC055), and have a procedure code type of 'HCPCS'. Drug Code as defined by the FDA in 11 digit format (5-4-2) without hyphenation	All	1%	B
MC	77	MC076	Billing Provider Number	6/24/10	Text	ID Link to PV002	varchar[30]	Billing Provider Number	Report the carrier / submitter assigned billing provider number. This number should be the identifier used for internal identification purposes, and does not routinely change. The value in this field must match a record in the provider file in	All	99%	B

									PV002.			
MC	78	MC077	National Provider ID - Billing	11/8/12	External Code Source 3 - Integer	External Code Source 3 - National Provider ID	int[10]	National Provider Identification (NPI) of the Billing Provider	Report the Primary National Provider ID (NPI) here. This ID should be found on the Provider File in the NPI field (PV039)	All	99%	B
MC	79	MC078	Billing Provider Last Name or Organization Name	6/24/10	Text	Name Last / Org Provider	varchar[60]	Last name or Organization Name of Billing Provider	Report the name of the organization or last name of the individual provider	All	99%	B
MC	80	MC079	Product ID Number	11/8/12	Text	ID Link to PR001	varchar[30]	Product Identification	Report the submitter-assigned identifier as it appears in PR001 in the Product File. This element is used to understand Product and Eligibility attributes of the member / subscriber as applied to this record	All	100%	A0
MC	81	MC080	Payment Reason	11/8/12	Carrier Defined Table **- OR -** External Code Source 16 - Text	External Code Source 16 - Claim Adjustment Reasons	varchar[10]	Payment Reason Code	Report the value that describes how the claim line was paid, either using a standard code set or a proprietary list pre-sent by submitter.	Required when MC038 = 01, 02, 03, 19, 20, or 21	100%	A0
MC	82	MC081	Capitated Encounter Flag	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Capitation Payment	Report the value that defines the element. **EXAMPLE:** 1 = Yes payment for this service is covered under a capitated arrangement.	All	100%	A0
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
MC	83	MC082	Member Street Address	11/8/12	Text	Address 1 Member	varchar[50]	Street address of the Member/Patient	Report the patient / member's address. Used to validate Unique Member ID.	All	90%	B

MC	84	MC083	Other ICD-CM Procedure Code - 1	11/8/12	External Codes Source 8 - Text	External Code Source 8 - ICDCM Procedure Codes	varchar[6]	ICD Secondary Procedure Code	Report the subsequent ICD CM procedure code when applicable. Repeat this code on all lines of the inpatient claim. Do not code decimal point.	Required when MC094 = 002 and MC039 is populated	1%	C
MC	85	MC084	Other ICD-CM Procedure Code - 2	11/8/12	External Codes Source 8 - Text	External Code Source 8 - ICDCM Procedure Codes	varchar[6]	ICD Other Procedure Code	Report the third ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Required when MC094 = 002 and MC039 is populated	1%	C
MC	86	MC085	Other ICD-CM Procedure Code - 3	11/8/12	External Codes Source 8 - Text	External Code Source 8 - ICDCM Procedure Codes	varchar[6]	ICD Other Procedure Code	Report the fourth ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Required when MC094 = 002 and MC039 is populated	1%	C
MC	87	MC086	Other ICD-CM Procedure Code - 4	11/8/12	External Codes Source 8 - Text	External Code Source 8 - ICDCM Procedure Codes	varchar[6]	ICD Other Procedure Code	Report the fifth ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Required when MC094 = 002 and MC039 is populated	1%	C
MC	88	MC087	Other ICD-CM Procedure Code - 5	11/8/12	External Codes Source 8 - Text	External Code Source 8 - ICDCM Procedure Codes	varchar[6]	ICD Other Procedure Code	Report the sixth ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Required when MC094 = 002 and MC039 is populated	1%	C
MC	89	MC088	Other ICD-CM Procedure Code - 6	11/8/12	External Codes Source 8 - Text	External Code Source 8 - ICDCM Procedure Codes	varchar[6]	ICD Other Procedure Code	Report the seventh ICD procedure code when applicable. The Integer point is not coded. The ICD procedure must be repeated for all lines of the claim if necessary.	Required when MC094 = 002 and MC039 is populated	1%	C
MC	90	MC089	Paid Date	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Paid date of the claim line	Report the date that appears on the check and/or remit and/or explanation of benefits and corresponds to any and all types of payment in CCYYMMDD Format. This can be the same date as Processed Date. **EXAMPLE:** Claims paid in full, partial or zero paid must	Required when MC038 = 01, 02, 03, 19, 20, or 21	98%	A0

									have a date reported here			
MC	91	MC090	LOINC Code	11/8/12	External Code Source 11 - Text	External Code Source 11 - LOINC	varchar[7]	Logical Observation Identifiers, Names and Codes (LOINC)	Report the LOINC here, a standardized test code (lab work) when applicable and available. Do not report any value if not applicable.	All	0%	B
MC	92	MC091	Coinsurance Days	11/8/12	Quantity - Integer	Days Partially Covered	±varchar[4]	Covered Coinsurance Days	Report the number of partially covered days the patient incurred during this admission. Report 0 if all days were covered and/or Noncovered days.	Required when MC094 = 002 and MC039 is populated	98%	B
MC	93	MC092	Covered Days	11/8/12	Quantity - Integer	Days Covered	±varchar[4]	Covered Inpatient Days	Report the number of covered days the patient incurred during this admission. Report 0 if days were Noncovered or partially covered under Coinsurance Days.	Required when MC094 = 002 and MC039 is populated	98%	B
MC	94	MC093	Non Covered Days	11/8/12	Quantity - Integer	Days Noncovered	±varchar[4]	Noncovered Inpatient Days	Report the number of Noncovered days the patient incurred during this admission. Report 0 if all days were covered.	Required when MC094 = 002 and MC039 is populated	87%	B
MC	95	MC094	Type of Claim	11/8/12	Lookup Table - Text	tlkpTypeOfClaim	char[3]	Type of Claim Indicator	Report the value that defines the type of claim submitted for payment. **EXAMPLE:** 001 = Professional Claim Line	All	100%	A0
								Value	***Description***			
								001	Professional			
								002	Facility			
								003	Reimbursement Form			
MC	96	MC095	Coordination of Benefits/TPL Liability Amount	11/8/12	Integer	Currency	±varchar[10]	Amount due from a Secondary Carrier when known	Report the amount that another carrier / insurer is liable for after submitting payer has processed this claim line. Report 0 if there is no COB / TPL amount. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is	Required when MC038 = 19, 20 or 21	98%	A2

									reported as 15070			
MC	97	MC096	Other Insurance Paid Amount	11/8/12	Integer	Currency	±varchar[10]	Amount paid by a Primary Carrier	Report the amount that a prior payer has paid for this claim line. Indicates the submitting Payer is 'secondary' to the prior payer. Only report 0 if the Prior Payer paid 0 towards this claim line, else do not report any value here. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC038 = 02, 03, 20, or 21	98%	A2
MC	98	MC097	Medicare Paid Amount	11/8/12	Integer	Currency	±varchar[10]	Amount Medicare paid on claim	Report the amount Medicare paid towards this claim line. Only report 0 here if Medicare paid 0. If Medicare did not pay towards this claim line do not report any value here. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC116 = 1	98%	A2
MC	99	MC098	Allowed amount	11/8/12	Integer	Currency	±varchar[10]	Allowed Amount	Report the maximum amount contractually allowed, and that a carrier will pay to a provider for a particular procedure or service. This will vary by provider contract and most often it is less than or equal to the fee charged by the provider. Report 0 when the claim line is denied. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC038 does not = 4, 22, or 23	99%	A2
MC	100	MC099	Non-Covered Amount	11/8/12	Integer	Currency	±varchar[10]	Amount of claim line charge not covered	Report the amount that was charged on a claim that is not reimbursable due to eligibility limitations or provider requirements. Report 0 if all charges are covered or fall into other categories. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is	All	98%	A2

									reported as 15000; 150.70 is reported as 15070			
MC	101	MC100	Delegated Benefit Administrator Organization ID	11/8/12	Integer	ID Link to OrgID	varchar[6]	CHIA defined and maintained Org ID for linking across submitters	Report the OrgID of the DBA here. This element contains the CHIA assigned organization ID for the DBA. Contact the APCD for the appropriate value. If no DBA is affiliated with this claim line do not report any value here: i.e., do not repeat the OrgID from MC001	All	98%	A2
MC	102	MC101	Subscriber Last Name	10/15/10	Text	Name Last Subscriber	varchar[60]	Last name of Subscriber	Report the last name of the subscriber. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. **EXAMPLE:** O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	98%	B
MC	103	MC102	Subscriber First Name	10/15/10	Text	Name First Subscriber	varchar[25]	First name of Subscriber	Report the first name of the subscriber here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. **EXAMPLE:** Anne-Marie becomes ANNEMARIE	All	98%	B
MC	104	MC103	Subscriber Middle Initial	10/15/10	Text	Name Middle Subscriber	char[1]	Middle initial of Subscriber	Report the Subscriber's middle initial here. Used to validate Unique Member ID.	All	2%	C
MC	105	MC104	Member Last Name	6/24/10	Text	Name Last Member	varchar[60]	Last name of Member/Patient	Report the last name of the patient / member here. Used to validate Unique Member ID. Last name should exclude all punctuation, including hyphens and apostrophes, and be reported in upper case. Name should be contracted where punctuation is removed, do not report spaces. **EXAMPLE:** O'Brien becomes OBRIEN; Carlton-Smythe becomes CARLTONSMYTHE	All	98%	B

MC	106	MC105	Member First Name	6/24/10	Text	Name First Member	varchar[25]	First name of Member/Patient	Report the first name of the patient / member here. Used to validate Unique Member ID. Exclude all punctuation, including hyphens and apostrophes. Name should be contracted where punctuation is removed, do not report spaces. **EXAMPLE:** Anne-Marie becomes ANNEMARIE	All	98%	B
MC	107	MC106	Member Middle Initial	6/24/10	Text	Name Middle Member	char[1]	Middle initial of Member/Patient	Report the middle initial of the patient / member when available. Used to validate Unique Member ID.	All	2%	C
MC	108	MC107	ICD Indicator	11/8/12	Lookup Table - Integer	tlkpICDIndicator	int[1]	International Classification of Diseases version	Report the value that defines whether the diagnoses on claim are ICD9 or ICD10. **EXAMPLE:** 9 = ICD9	Required when MC094 = 001 or 002 and MC039 thru MC053, MC142 thru MC153 is populated	100%	B
								Value	***Description***			
								9	ICD-9			
								0	ICD-10			
MC	109	MC108	Procedure Modifier - 3	11/8/12	External Code Source 9 - Text	External Code Source 9 - Modifiers	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	All	0%	C
MC	110	MC109	Procedure Modifier - 4	11/8/12	External Code Source 9 - Text	External Code Source 9 - Modifiers	char[2]	HCPCS / CPT Code Modifier	Report a valid Procedure modifier when a modifier clarifies / improves the reporting accuracy of the associated procedure code (MC055).	All	0%	C
MC	111	MC110	Claim Processed Date	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Claim Processed Date	Report the date the claim was processed by the carrier / submitter in CCYYMMDD Format. This date can be equal to Paid Date, but cannot be after Paid Date.	All	98%	A2

MC	112	MC111	Diagnostic Pointer	11/8/12	Integer	ID Diagnosis	varchar[4]	Diagnostic Pointer Number	Report the placement number of the diagnosis(es) a procedure is related to for a professional claim. Can report up to four diagnostic positions within the first nine diagnoses that can be reported. Do not separate multiple mappings with spaces, zeros or special characters. Do not zero fill. **EXAMPLE:** Procedure related to diagnoses 1, 4 and 5 = 145	Required when MC094 = 001	98%	B
MC	113	MC112	Referring Provider ID	11/8/12	Text	ID Link to PV002	varchar[30]	Referring Provider ID	Report the identifier of the provider that submitted the referral for the service or ordered the test that is on the claim (if applicable). The value in this field must have a corresponding Provider ID (PV002) on the provider file.	Required when MC118 = 1	98%	A2
MC	114	MC113	Payment Arrangement Type	11/8/12	Lookup Table - Numeric	tlkpPaymentArrangementType	char[2]	Payment Arrangement Type Value	Report the value that defines the contracted payment methodology for this claim line. **EXAMPLE:** 02 = Fee for Service	All	98%	A0
								Value	***Description***			
								01	Capitation			
								02	Fee for Service			
								03	Percent of Charges			
								04	DRG			
								05	Pay for Performance			
								06	Global Payment			
								07	Other			
								08	Bundled Payment			
MC	115	MC114	Excluded Expenses	11/8/12	Integer	Currency	±varchar[10]	Amount not covered at the claim line due to benefit/plan limitation	Report the amount that the patient has incurred towards covered but over-utilized services. Scenario: Physical Therapy units that are authorized for 15 visits at $50 a visit but utilized 20. The amount reported here would be 25000 to state over-utilization by $250.00. Report 0 if there are no Excluded Expenses. Do	All	98%	A2

									not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070			
MC	116	MC115	Medicare Indicator	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Medicare Payment Applied	Report the value that defines the element. **EXAMPLE:** 1 = Yes, Medicare paid for part or all of services.	All	100%	A0
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
MC	117	MC116	Withhold Amount	11/8/12	Integer	Currency	±varchar[10]	Amount to be paid to the provider upon guarantee of performance	Report the amount paid to the provider for this claim line if the provider qualified / met performance guarantees. Report 0 if the provider has the agreement but did not satisfy the measure, else do not report any value here. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. EXAMPLE: 150.00 is reported as 15000; 150.70 is reported as 15070	All	98%	A2
MC	118	MC117	Authorization Needed	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Authorization Needed	Report the value that defines the element. **EXAMPLE:** 1 = Yes service required a pre-authorization.	All	100%	A2
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			

MC	119	MC118	Referral Indicator	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Referral Needed	Report the value that defines the element. **EXAMPLE:** 1 = Yes service was preceded by a referral.	All	100%	A0
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
MC	120	MC119	PCP Indicator	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - PCP Rendered Service	Report the value that defines the element. **EXAMPLE:** 1 = Yes service was performed by members PCP.	All	100%	A2
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
MC	121	MC120	DRG Level	11/8/12	External Code Source 15 - Integer	External Code Source 15 - DRG	int[1]	Diagnostic Related Group Code Severity Level	Report the level used for severity adjustment when applicable.	Required when MC071 is populated	80%	B
MC	122	MC121	Patient Total Out of Pocket Amount	11/8/12	Integer	Currency	±varchar[10]	Total amount patient/member must pay	Report the total amount patient / member is responsible to pay to the provider as part of their costs for services. Report 0 if there are no Out of Pocket expenses. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	All	100%	A2
MC	123	MC122	Global Payment Flag	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Global Payment	Report the value that defines the element. **EXAMPLE:** 1 = Yes the claim line was paid under a global	All	100%	A0

									payment arrangement.			
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
MC	124	MC123	Denied Flag	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Denied Claim Line Indicator	Report the value that defines the element. **EXAMPLE:** 1 = Yes, Claim Line was denied.	Required when MC038 = 04	100%	A0
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
MC	125	MC124	Denial Reason	11/8/12	Carrier Defined Table **- OR -** External Code Source 16 - Text	External Code Source 16 - Denial Reason	varchar[15]	Denial Reason Code	Report the code that defines the reason for denial of the claim line. Carrier must submit denial reason codes in separate table to the APCD.	Required when MC123 = 1	98%	A2
MC	126	MC125	Attending Provider	11/8/12	Text	ID Link to PV002	varchar[30]	Attending Provider ID	Report the ID that reflects the provider that provided general oversight of the patient's care. This individual may or may not be the Servicing or Rendering provider. This value needs to be found in field PV002 on the Provider File. This field may or may not be NPI based on the carrier's identifier system.	Required when MC094 = 002 and MC039 is populated	98%	A1
MC	127	MC126	Accident Indicator	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Accident Related	Report the value that defines the element. **EXAMPLE:** 1 = Yes, Claim Line is Accident related.	All	100%	A2

								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
MC	128	MC127	Family Planning Indicator	11/8/12	Lookup Table - Integer	tlkpFamilyPlanning	int[1]	Service is related to Family Planning	Report the value the defines if family planning services were provided. **EXAMPLE:** 0 = Unknown / Not Applicable	All	98%	A2
								Value	***Description***			
								1	Family planning services provided			
								2	Abortion services provided			
								3	Sterilization services provided			
								4	No family planning services provided			
								0	Unknown / Not Applicable / Not Avail			
MC	129	MC128	Employment Related Indicator	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Accident Related	Report the value that defines the element. **EXAMPLE:** 1 = Yes, Claim Line was related to employment accident.	All	100%	A2
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
MC	130	MC129	EPSDT Indicator	11/8/12	Lookup Table - Integer	tlkpEPSDTIndicator	int[1]	Service related to Early Periodic Screening, Diagnosis and Treatment (EPSDT)	Report the value that defines if service was related to EPSDT and the type of EPSDT service, such as 'screening', 'treatment' or 'referral'. **EXAMPLE:** 0 = Unknown / Not Applicable	All	98%	B
								Value	***Description***			

								1	EPSDT Screen			
								2	EPSDT Treatment			
								3	EPSDT Referral			
								0	Unknown / Not Applicable / Not Available			
MC	131	MC130	Procedure Code Type	11/8/12	Lookup Table - Integer	tlkpProcedureCodeType	int[1]	Claim line Procedure Code Type Identifier	Report the value the defines the type of Procedure Code expected in MC055.	All	98%	A1
								Value	***Description***			
								1	CPT or HCPCS Level 1 Code			
								2	HCPCS Level II Code			
								3	HCPCS Level III Code (State Medicare code).			
								4	American Dental Association (ADA) Procedure Code (Also referred to as CDT code.)			
								5	State defined Procedure Code			
								6	CPT Category II			
								7	Custom Code - Submitter must send in a lookup table of values for MC055			
MC	132	MC131	InNetwork Indicator	11/8/12	Lookup Table - Integer	tlkpFlagIndicators	int[1]	Indicator - Network Rate Applied	Report the value that defines the element. **EXAMPLE:** 1 = Yes claim line was paid at an InNetwork rate.	All	100%	A2
								Value	***Description***			
								1	Yes			
								2	No			
								3	Unknown			
								4	Other			
								5	Not Applicable			
MC	133	MC132	Service Class	6/24/10	Carrier Defined Table - Text	Carrier Defined Table - MCO Service Class	char[2]	Service Class Code	Report the code that defines the service class for Medicaid PCC members receiving behavioral health services (values based on MassHealth encounter table)	Required when Submitter is identified as a MassHealt	10%	C

										h / MCO Submitter		
MC	134	MC133	Bill Frequency Code	11/8/12	External Code Source 14 - Text	External Code Source 14 - Type of Bill	char[1]	Bill Frequency	Report the valid frequency code of the claim to indicate version, credit/debit activity and/or setting of claim.	Required when MC094 = 001 or 002	100%	A2
MC	135	MC134	Plan Rendering Provider Identifier	11/8/12	Text	ID Link to PV002	varchar[30]	Plan Rendering Number	Report the unique code which identifies for the carrier / submitter who or which individual provider cared for the patient for the claim line in question. This code must be able to link to the Provider File. Any value in this field must also show up as a value in field PV002 (Provider ID) on the Provider File.	All	100%	A0
MC	136	MC135	Provider Location	11/8/12	Text	ID Link to PV002	varchar[30]	Location of Provider	Report the unique code which identifies the location / site of the service provided by the provider identified in MC134. The code should link to a provider record in field PV002 (Provider ID) and indicate that the service was performed at a specific location; e.g.: Dr. Jones Pediatrics, 123 Main St, Boston, MA, or Pediatric Associates, or Mass General Hospital, etc. Only the code is needed in this field, and the link to the Provider ID in the provider ID will allow the physical address and other identifying information about the service location to be captured. Type of location is an incorrect value.	All	98%	A2
MC	137	MC136	Discharge Diagnosis	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Discharge Diagnosis Code	Report the ICD diagnosis code as applied to the patient upon discharge. This may or may not be the same as the primary diagnosis or admitting diagnosis.	Required when MC069 is populated	80%	B
MC	138	MC137	Carrier Specific Unique Member ID	11/8/12	Text	ID Link to ME107	varchar[50]	Member's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the member. Used to validate Unique Member ID and link back to Member Eligibility (ME107)	All	100%	A0

MC	139	MC138	Claim Line Type	11/8/12	Lookup Table - Text	tlkpClaimLineType	char[1]	Claim Line Activity Type Code	Report the code that defines the claim line status in terms of adjudication. **EXAMPLE:** O = Original	All	98%	A2
								Code	***Description***			
								O	Original			
								V	Void			
								R	Replacement			
								B	Back Out			
								A	Amendment			
MC	140	MC139	Former Claim Number	12/1/10	Text	ID Claim Number	varchar[35]	Previous Claim Number	Report the Claim Control Number (MC004) that was originally sent in a prior filing that this line corresponds to. When reported, this data cannot equal its own MC004. Use of "Former Claim Number" to version claims can **only** be used if approved by the APCD. Contact the APCD for conditions of use.	All	0%	B
MC	141	MC140	Member Street Address 2	11/8/12	Text	Address 2 Member	varchar[50]	Secondary Street Address of the Member/Patient	Report the address of member which may include apartment number or suite, or other secondary information besides the street. Used to validate Unique Member ID.	All	1%	B
MC	142	MC141	Carrier Specific Unique Subscriber ID	11/8/12	Text	ID Link to ME117	varchar[50]	Subscriber's Unique ID	Report the identifier the carrier / submitter uses internally to uniquely identify the subscriber. Used to validate Unique Member ID and link back to Member Eligibility (ME117)	All	100%	A0
MC	143	MC142	Other Diagnosis - 13	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 13. If not applicable do not report any value here	All	1%	C
MC	144	MC143	Other Diagnosis - 14	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 14. If not applicable do not report any value here	All	1%	C

MC	145	MC144	Other Diagnosis - 15	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 15. If not applicable do not report any value here	All	1%	C
MC	146	MC145	Other Diagnosis - 16	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 16. If not applicable do not report any value here	All	1%	C
MC	147	MC146	Other Diagnosis - 17	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 17. If not applicable do not report any value here	All	1%	C
MC	148	MC147	Other Diagnosis - 18	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 18. If not applicable do not report any value here	All	1%	C
MC	149	MC148	Other Diagnosis - 19	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 19. If not applicable do not report any value here	All	1%	C
MC	150	MC149	Other Diagnosis - 20	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 20. If not applicable do not report any value here	All	1%	C
MC	151	MC150	Other Diagnosis - 21	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 21. If not applicable do not report any value here	All	1%	C

MC	152	MC151	Other Diagnosis - 22	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 22. If not applicable do not report any value here	All	1%	C
MC	153	MC152	Other Diagnosis - 23	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 23. If not applicable do not report any value here	All	1%	C
MC	154	MC153	Other Diagnosis - 24	11/8/12	External Code Source 8 - Text	External Codes Source 8 - International Classification of Diseases	varchar[7]	ICD Other Diagnosis Code	Other ICD Diagnosis Code - 24. If not applicable do not report any value here	All	1%	C
MC	155	MC154	Present on Admission Code (POA) - 01	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Principal Diagnosis	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC041 is populated	100%	A2
MC	156	MC155	Present on Admission Code (POA) - 02	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 1	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC042 is populated	100%	A2
MC	157	MC156	Present on Admission Code (POA) - 03	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 2	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC043 is populated	100%	A2

MC	158	MC157	Present on Admission Code (POA) - 04	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 3	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC044 is populated	100%	A2
MC	159	MC158	Present on Admission Code (POA) - 05	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 4	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC045 is populated	100%	A2
MC	160	MC159	Present on Admission Code (POA) - 06	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 5	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC046 is populated	100%	A2
MC	161	MC160	Present on Admission Code (POA) - 07	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 6	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC047 is populated	100%	A2
MC	162	MC161	Present on Admission Code (POA) - 08	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 7	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC048 is populated	100%	A2
MC	163	MC162	Present on Admission Code (POA) - 09	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 8	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for	Required when MC094 = 002, MC039	100%	A2

									exempt.	and MC049 is populated		
MC	164	MC163	Present on Admission Code (POA) - 10	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 9	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC050 is populated	100%	A2
MC	165	MC164	Present on Admission Code (POA) - 11	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 10	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC051 is populated	100%	A2
MC	166	MC165	Present on Admission Code (POA) - 12	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 11	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC052 is populated	100%	A2
MC	167	MC166	Present on Admission Code (POA) - 13	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 12	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC053 is populated	100%	A2
MC	168	MC167	Present on Admission Code (POA) - 14	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 13	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC142 is populated	100%	A2

MC	169	MC168	Present on Admission Code (POA) - 15	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 14	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC143 is populated	100%	A2
MC	170	MC169	Present on Admission Code (POA) - 16	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 15	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC144 is populated	100%	A2
MC	171	MC170	Present on Admission Code (POA) - 17	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 16	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC145 is populated	100%	A2
MC	172	MC171	Present on Admission Code (POA) - 18	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 17	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC146 is populated	100%	A2
MC	173	MC172	Present on Admission Code (POA) - 19	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 18	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC147 is populated	100%	A2
MC	174	MC173	Present on Admission Code (POA) - 20	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 19	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for	Required when MC094 = 002, MC039	100%	A2

									exempt.	and MC148 is populated		
MC	175	MC174	Present on Admission Code (POA) - 21	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 20	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC149 is populated	100%	A2
MC	176	MC175	Present on Admission Code (POA) - 22	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 21	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC150 is populated	100%	A2
MC	177	MC176	Present on Admission Code (POA) - 23	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 22	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC151 is populated	100%	A2
MC	178	MC177	Present on Admission Code (POA) - 24	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 23	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC152 is populated	100%	A2
MC	179	MC178	Present on Admission Code (POA) - 25	11/8/12	External Code Source 15 - Text	External Code Source 15 - Present on Admission	char[1]	POA code for Other Diagnosis - 24	Report the appropriate value from the lookup table to describe diagnosis presence upon admission. Do not report blanks in lieu of Exempt, reporting 1 is required for exempt.	Required when MC094 = 002, MC039 and MC153 is populated	100%	A2

MC	180	MC179	Condition Code - 1	11/8/12	External Code Source 14 - Text	External Code Source 14 - Condition Codes	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	181	MC180	Condition Code - 2	11/8/12	External Code Source 14 - Text	External Code Source 14 - Condition Codes	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	182	MC181	Condition Code - 3	11/8/12	External Code Source 14 - Text	External Code Source 14 - Condition Codes	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	183	MC182	Condition Code - 4	11/8/12	External Code Source 14 - Text	External Code Source 14 - Condition Codes	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	184	MC183	Condition Code - 5	11/8/12	External Code Source 14 - Text	External Code Source 14 - Condition Codes	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	185	MC184	Condition Code - 6	11/8/12	External Code Source 14 - Text	External Code Source 14 - Condition Codes	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	186	MC185	Condition Code - 7	11/8/12	External Code Source 14 - Text	External Code Source 14 - Condition Codes	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	187	MC186	Condition Code - 8	11/8/12	External Code Source 14 - Text	External Code Source 14 - Condition Codes	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	188	MC187	Condition Code - 9	11/8/12	External Code Source 14 - Text	External Code Source 14 - Condition Codes	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	189	MC188	Condition Code - 10	11/8/12	External Code Source 14 - Text	External Code Source 14 - Condition Codes	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	190	MC189	Condition Code - 11	11/8/12	External Code Source 14 - Text	External Code Source 14 - Condition Codes	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here	All	1%	B

MC	191	MC190	Condition Code - 12	11/8/12	External Code Source 14 - Text	External Code Source 14 - Condition Codes	char[2]	Condition Code	Report the appropriate value that defines a condition of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	192	MC191	Value Code - 1	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here	All	1%	B
MC	193	MC192	Value Amount - 1	11/8/12	Integer	Currency	±varchar[10]	Amount that corresponds to Value Code - 1	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC191 is populated	100%	B
MC	194	MC193	Value Code - 2	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here	All	1%	B
MC	195	MC194	Value Amount - 2	11/8/12	Integer	Currency	±varchar[10]	Amount that corresponds to Value Code - 2	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC193 is populated	100%	B
MC	196	MC195	Value Code - 3	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here	All	1%	B
MC	197	MC196	Value Amount - 3	11/8/12	Integer	Currency	±varchar[10]	Amount that corresponds to Value Code - 3	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC195 is populated	100%	B

MC	198	MC197	Value Code - 4	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here	All	1%	B
MC	199	MC198	Value Amount - 4	11/8/12	Integer	Currency	±varchar[10]	Amount that corresponds to Value Code - 4	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC197 is populated	100%	B
MC	200	MC199	Value Code - 5	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here	All	1%	B
MC	201	MC200	Value Amount - 5	11/8/12	Integer	Currency	±varchar[10]	Amount that corresponds to Value Code - 5	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC199 is populated	100%	B
MC	202	MC201	Value Code - 6	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here	All	1%	B
MC	203	MC202	Value Amount - 6	11/8/12	Integer	Currency	±varchar[10]	Amount that corresponds to Value Code - 6	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC201 is populated	100%	B
MC	204	MC203	Value Code - 7	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here	All	1%	B

MC	205	MC204	Value Amount - 7	11/8/12	Integer	Currency	±varchar[10]	Amount that corresponds to Value Code - 7	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC203 is populated	100%	B
MC	206	MC205	Value Code - 8	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here	All	1%	B
MC	207	MC206	Value Amount - 8	11/8/12	Integer	Currency	±varchar[10]	Amount that corresponds to Value Code - 8	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC205 is populated	100%	B
MC	208	MC207	Value Code - 9	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here	All	1%	B
MC	209	MC208	Value Amount - 9	11/8/12	Integer	Currency	±varchar[10]	Amount that corresponds to Value Code - 9	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC207 is populated	100%	B
MC	210	MC209	Value Code - 10	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here	All	1%	B
MC	211	MC210	Value Amount - 10	11/8/12	Integer	Currency	±varchar[10]	Amount that corresponds to Value Code - 10	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down	Required when MC209 is populated	100%	B

									to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070			
MC	212	MC211	Value Code - 11	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here	All	1%	B
MC	213	MC212	Value Amount - 11	11/8/12	Integer	Currency	±varchar[10]	Amount that corresponds to Value Code - 11	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC211 is populated	100%	B
MC	214	MC213	Value Code - 12	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Value Code	Report the appropriate value that defines a value category of the claim. If not applicable do not report any value here	All	1%	B
MC	215	MC214	Value Amount - 12	11/8/12	Integer	Currency	±varchar[10]	Amount that corresponds to Value Code - 12	Report the appropriate amount that corresponds to the value code. Only code 0 when 0 is an applicable amount for the Value Code Set. Do not code decimal or round up / down to whole dollars, code zero cents (00) when applicable. **EXAMPLE:** 150.00 is reported as 15000; 150.70 is reported as 15070	Required when MC213 is populated	100%	B
MC	216	MC215	Occurrence Code - 1	11/8/12	External Code Source 14 - Text	External Code Source 14 - Occurrence Codes	char[2]	Occurrence Code	Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here	All	1%	B
MC	217	MC216	Occurrence Date - 1	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Date that corresponds to Occurrence Code - 1	Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC215 is populated	100%	B
MC	218	MC217	Occurrence Code - 2	11/8/12	External Code Source 14 - Text	External Code Source 14 - Occurrence Codes	char[2]	Occurrence Code	Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here	All	1%	B

MC	219	MC218	Occurrence Date - 2	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Date that corresponds to Occurrence Code - 2	Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC217 is populated	100%	B
MC	220	MC219	Occurrence Code - 3	11/8/12	External Code Source 14 - Text	External Code Source 14 - Occurrence Codes	char[2]	Occurrence Code	Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here	All	1%	B
MC	221	MC220	Occurrence Date - 3	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Date that corresponds to Occurrence Code - 3	Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC219 is populated	100%	B
MC	222	MC221	Occurrence Code - 4	11/8/12	External Code Source 14 - Text	External Code Source 14 - Occurrence Codes	char[2]	Occurrence Code	Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here	All	1%	B
MC	223	MC222	Occurrence Date - 4	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Date that corresponds to Occurrence Code - 4	Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC221 is populated	100%	B
MC	224	MC223	Occurrence Code - 5	11/8/12	External Code Source 14 - Text	External Code Source 14 - Occurrence Codes	char[2]	Occurrence Code	Report the appropriate value that defines an occurrence category for the claim or patient. If not applicable do not report any value here	All	1%	B
MC	225	MC224	Occurrence Date - 5	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Date that corresponds to Occurrence Code - 5	Report the appropriate date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC223 is populated	100%	B
MC	226	MC225	Occurrence Span Code - 1	11/8/12	External Code Source 14 - Text	External Code Source 14 - Occurrence Span Codes	char[2]	Occurrence Span Code	Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	227	MC226	Occurrence Span Start Date - 1	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Start Date that corresponds to Occurrence Span Code - 1	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC225 is populated	100%	B
MC	228	MC227	Occurrence Span End Date - 1	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	End Date that corresponds to Occurrence Span Code - 1	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC226 is populated	100%	B

MC	229	MC228	Occurrence Span Code - 2	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Occurrence Span Code	Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	230	MC229	Occurrence Span Start Date - 2	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Start Date that corresponds to Occurrence Span Code - 2	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC228 is populated	100%	B
MC	231	MC230	Occurrence Span End Date - 2	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	End Date that corresponds to Occurrence Span Code - 2	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC229 is populated	100%	B
MC	232	MC231	Occurrence Span Code - 3	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Occurrence Span Code	Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	233	MC232	Occurrence Span Start Date - 3	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Start Date that corresponds to Occurrence Span Code - 3	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC231 is populated	100%	B
MC	234	MC233	Occurrence Span End Date - 3	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	End Date that corresponds to Occurrence Span Code - 3	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC232 is populated	100%	B
MC	235	MC234	Occurrence Span Code - 4	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Occurrence Span Code	Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here	All	1%	B
MC	236	MC235	Occurrence Span Start Date - 4	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Start Date that corresponds to Occurrence Span Code - 4	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC234 is populated	100%	B
MC	237	MC236	Occurrence Span End Date - 4	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	End Date that corresponds to Occurrence Span Code - 4	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC235 is populated	100%	B
MC	238	MC237	Occurrence Span Code - 5	11/8/12	External Code Source 14 - Text	External Code Source 14 - Value Codes	char[2]	Occurrence Span Code	Report the appropriate code that defines an occurrence span category of the claim or patient. If not applicable do not report any value here	All	1%	B

MC	239	MC238	Occurrence Span Start Date - 5	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Start Date that corresponds to Occurrence Span Code - 5	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC237 is populated	100%	B
MC	240	MC239	Occurrence Span End Date - 5	11/8/12	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	End Date that corresponds to Occurrence Span Code - 5	Report the appropriate start date that corresponds to the occurrence code in CCYYMMDD Format.	Required when MC238 is populated	100%	B
MC	241	MC240	GIC ID	11/8/12	Text	ID GIC	varchar[9]	GIC Member ID	Report the GIC Member Identification number as provided to GIC Plan Submitters. If not applicable do not report any value here	Required when MC241 = 3	100%	A0
MC	242	MC241	APCD ID Code	11/8/12	Lookup Table - Integer	tlkpADCDIdentifier	int[1]	Member Enrollment Type	Report the value that describes the member's / subscriber's enrollment into one of the predefined categories; aligns enrollment to appropriate editing and thresholds. **EXAMPLE:** 1 = FIG - Fully Insured Commercial Group Enrollee.	All	100%	A2
								Value	***Description***			
								1	FIG - Fully-Insured Commercial Group Enrollee			
								2	SIG - Self-Insured Group Enrollee			
								3	GIC - Group Insurance Commission Enrollee			
								4	MCO - MassHealth Managed Care Organization Enrollee			
								5	Supplemental Policy Enrollee			
								0	Unknown / Not Applicable			
MC	243	MC899	Record Type	6/24/10	Text	ID File	char[2]	File Type Identifier	Report **MC** here. This validates the type of file and the data contained within the file. This must match HD004	All	100%	A0
TR-MC	1	TR001	Record Type	6/24/10	Text	ID Record	char[2]	Trailer Record Identifier	Report **TR** here. Indicates the end of the data file	Mandatory	100%	TM
TR-MC	2	TR002	Submitter	11/8/12	Integer	ID Submitter	varchar[6]	Trailer Submitter / Carrier ID defined by CHIA	Report the Unique Submitter ID as defined by CHIA here. This must match the Submitter ID reported in HD002	Mandatory	100%	TM

TR-MC	3	TR003	National Plan ID	11/8/12	Integer	ID Nat'l PlanID	int[10]	CMS National Plan Identification Number (PlanID)	Do not report any value here until National PlanID is fully implemented. This is a unique identifier as outlined by Centers for Medicare and Medicaid Services (CMS) for Plans or Sub plans	Situational	0%	TS
TR-MC	4	TR004	Type of File	6/24/10	Text	ID File	char[2]	Validates the file type defined in HD004.	Report **MC** here. This must match the File Type reported in HD004	Mandatory	100%	TM
TR-MC	5	TR005	Period Beginning Date	6/24/10	Date Period - Integer	Century Year Month - CCYYMM	int[6]	Trailer Period Start Date	Report the Year and Month of the reported submission period in CCYYMM format. This date period must match the date period reported in HD005 and HD006	Mandatory	100%	TM
TR-MC	6	TR006	Period Ending Date	6/24/10	Date Period - Integer	Century Year Month - CCYYMM	int[6]	Trailer Period Ending Date	Report the Year and Month of the reporting submission period in CCYYMM format. This date period must match the date period reported in TR005 and HD005 and HD006	Mandatory	100%	TM
TR-MC	7	TR007	Date Processed	6/24/10	Full Date - Integer	Century Year Month Day - CCYYMMDD	int[8]	Trailer Processed Date	Report the full date that the submission was compiled by the submitter in CCYYMMDD Format.	Mandatory	100%	TM

Appendix D – External Code Sources

1. Countries

American National Standards Institute
http://webstore.ansi.org/SdoInfo.aspx?sdoid=39&source=iso_member_body

MC070

2. States, Zip Codes and Other Areas of the US

U.S. Postal Service
https://www.usps.com/

MC015	MC016	MC034	MC035

3. National Provider Identifiers

National Plan & Provider Enumeration System
https://nppes.cms.hhs.gov/NPPES/

MC026	MC027

4. Provider Specialties

OptumInsight Specialty Codes
http://www.optuminsight.com/transparency/etg-links/episode-treatment-groups/

MC032

5. Health Care Provider Taxonomy

Washington Publishing Company
http://www.wpc-edi.com/reference/

MC032

8. International Classification of Diseases 9 & 10

American Medical Association
http://www.ama-assn.org/

MC039	MC040	MC041	MC042	MC043	MC044	MC045	MC046	MC047	MC048
MC050	MC049	MC051	MC052	MC053	MC058	MC083	MC084	MC085	MC086
MC088	MC136	MC142	MC087	MC143	MC144	MC145	MC146	MC147	MC148
MC149	MC150	MC151	MC152	MC153					

9. HCPCS, CPTs and Modifiers

American Medical Association
http://www.ama-assn.org/

MC055	MC056	MC057	MC108	MC109

10. Dental Procedure Codes and Identifiers

American Dental Association
http://www.ada.org/

MC055

11. Logical Observation Identifiers Names and Codes

Regenstrief Institute
http://loinc.org/

MC090

12. National Drug Codes and Names

U.S. Food and Drug Administration
http://www.fda.gov/drugs/informationondrugs/ucm142438.htm

MC075

13. Standard Professional Billing Elements

Centers for Medicare and Medicaid Services (Rev. 10/26/12)
http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf

MC037

14. Standard Facility Billing Elements

National Uniform Billing Committee (NUBC)
http://www.nubc.org/

MC020	MC021	MC023	MC036	MC054	MC133	MC179	MC180	MC181	MC182
MC183	MC184	MC185	MC186	MC187	MC188	MC189	MC190	MC191	MC193
MC195	MC197	MC199	MC201	MC203	MC205	MC207	MC209	MC211	MC213
MC215	MC217	MC219	MC221	MC223	MC225	MC228	MC231	MC234	MC237

15. DRGs, APCs and POA Codes

Centers for Medicare and Medicaid Services
http://www.cms.gov/

MC071	MC072	MC073	MC074	MC120	MC154	MC155	MC156	MC157	MC158
MC159	MC160	MC161	MC162	MC163	MC164	MC165	MC166	MC167	MC168
MC169	MC170	MC171	MC172	MC173	MC174	MC175	MC176	MC177	MC178

16. Claim Adjustment Reason Codes

Washington Publishing Company
http://www.wpc-edi.com/reference/

MC080	MC124

The Commonwealth of Massachusetts
Center for Health Information and Analysis

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Boston, MA 02116-4737
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Fax: (617) 727-7662
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